# Permission for Medication
# Norwood School District R-1

*To be filled by prescribing physician and parent*

Name of Student: _____ Grade: _____

Medication Name: _____ Dosage: _____

Purpose of medication: _____

Time of Day To Be Given: _____

Possible Side Effects: _____

_____

Anticipated Number of Days Medication Will Be Given: _____

Date: _____ _____

*Physician's Signature*

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by the Ouray School District, the undersigned parent or guardian hereby agrees to release the Ouray School District and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

I hereby give my permission for _____ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication.

Date: _____ _____

*Signature of Parent or Guardian*

**NOTE:** The prescription medication must be brought to school in a container appropriately labeled by the pharmacy or physician stating the name of the medication and the dosage.